Complete Summary

GUIDELINE TITLE

Tobacco use prevention and cessation for infants, children and adolescents.

BIBLIOGRAPHIC SOURCE(S)

Institute for Clinical Systems Improvement (ICSI). Tobacco use prevention and cessation for infants, children and adolescents. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2004 Jun. 28 p. [25 references]

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY

SCOPE

DISEASE/CONDITION(S)

- Passive tobacco exposure
- Tobacco use and addiction

GUIDELINE CATEGORY

Counseling
Prevention

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology
Pediatrics
Preventive Medicine
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Health Plans
Hospitals
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

- To define the appropriate interventions in the clinic setting for identification of tobacco-use status in infants, children, and adolescents, and for provision of counseling and assistance in tobacco-use cessation
- To improve the proportion of patients whose current use of tobacco or exposure to tobacco smoke is obvious in the chart at any primary care clinic encounter
- To improve the proportion of tobacco-users whose interest in quitting is assessed or who receive cessation advice at any clinic encounter
- To increase the number of tobacco-using patients who will quit
- To improve the proportion of clinic-visiting tobacco users setting a quit date who received self-help materials along with telephone help-line information

TARGET POPULATION

Infants, children, and adolescents

INTERVENTIONS AND PRACTICES CONSIDERED

1. Community intervention, including school-based education, limiting youth access to tobacco, restrictions on advertising, counter-advertising, increasing economic disincentives to tobacco use, and establishing smoke-free public places
2. Tobacco use identification and cessation clinic program, including frequent assessment to establish tobacco use or exposure to second-hand smoke, counseling, encouragement to quit, self-help and educational material (pamphlets, audio and video information) on short-term negative effects of smoking, benefits of quitting, and refusal skills, advice on smoking cessation, and follow-up by mail or telephone after quit date

MAJOR OUTCOMES CONSIDERED

- Quit rate
- Smoking prevalence in Minnesota high-school and middle-school students

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

No additional description of literature search strategies is available.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Clinical Validation-Pilot Testing
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Institute Partners: System-Wide Review

The guideline draft, discussion, and measurement specification documents undergo thorough review. Written comments are solicited from clinical, measurement, and management experts from within the member medical groups during an eight-week period of "Critical Review."

Each of the Institute's participating medical groups determines its own process for distributing the guideline and obtaining feedback. Clinicians are asked to suggest modifications based on their understanding of the clinical literature coupled with their clinical expertise. Representatives from all departments involved in implementation and measurement review the guideline to determine its operational impact. Measurement specifications for selected measures are developed by the Institute for Clinical Systems Improvement (ICSI) in collaboration with participating medical groups following general implementation of the guideline. The specifications suggest approaches to operationalizing the measure.

Guideline Work Group: Second Draft

Following the completion of the "Critical Review" period, the guideline work group meets 1-2 times to review the input received. The original guideline is revised as necessary, and a written response is prepared to address each of the suggestions received from medical groups. Two members of the Preventive Services Steering Committee carefully review the Critical Review input, the work group responses, and the revised draft of the guideline. They report to the entire committee their assessment of two questions: (1) Have the concerns of the medical groups been adequately addressed? (2) Are the medical groups willing and able to implement the guideline? The committee then either approves the guideline for pilot testing as submitted or negotiates changes with the work group representative present at the meeting.

Pilot Test

Medical groups introduce the guideline at pilot sites, providing training to the clinical staff and incorporating it into the organization's scheduling, computer, and other practice systems. Evaluation and assessment occur throughout the pilot test phase, which usually lasts for six months. Comments and suggestions are solicited in the same manner as used during the "Critical Review" phase.

The guideline work group meets to review the pilot sites' experiences and makes the necessary revisions to the guideline, and the Preventive Services Steering Committee reviews the revised guideline and approves it for implementation.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Recommendations for tobacco use prevention and cessation for infants, children, and adolescents are presented in the form of an algorithm, with two sections: "Infants and Children from Birth to 10 Years Old" and "Children and Adolescents Aged 10 Years and Above," containing a total of 17 components and accompanied

by detailed annotations. Clinical highlights and selected annotations (numbered to correspond with the algorithm) follow.

Class of evidence (A-D, M, R, X) definitions are provided at the end of the "Major Recommendations" field.

Clinical Highlights

1. Ask about tobacco use and secondhand smoke exposure at every opportunity. (Annotations #2, 8)
2. Advise all tobacco users to stop. (Annotation #6, 17)
3. Assess tobacco user's willingness to make a quit attempt. (Annotation #12)
4. Assist tobacco user's efforts to quit. (Annotation #6, 14,17)
5. Arrange for follow-up. (Annotations #6, 17)

Infants and Children from Birth to 10 Years Old Algorithm Annotations

1. Community Intervention

   Key Points:

   - Tobacco use is the single most preventable cause of disease and death in our society.
   - The work group urges Institute for Clinical Systems Improvement (ICSI) participating medical groups, insurance plans and employers to actively intervene within their community to reduce tobacco use.

   Tobacco use is the single most preventable cause of disease and death in our society. The Centers for Disease Control recommend that tobacco control programs be established that are comprehensive, sustainable, and accountable. The goal of a comprehensive tobacco control program is to reduce disease, disability and death related to tobacco use by:

   - Preventing the initiation of tobacco use among young people
   - Promoting cessation among young people and adults
   - Eliminating nonsmokers' exposure to second hand smoke
   - Identifying and eliminating the disparities related to tobacco use and its effects among different population groups

   The components of a comprehensive tobacco control program include:

   - Community programs to reduce tobacco use
   - Chronic disease programs to reduce the burden of tobacco related diseases
   - School programs
   - Enforcement
   - Statewide programs
   - Counter-marketing
   - Cessation programs
   - Surveillance and evaluation

- Administration and management

The work group urges ICSI medical groups, insurance plans, and employers to actively intervene within their community to reduce tobacco use. Participation in school-based education, limiting youth access to tobacco, restrictions on advertising, counter-advertising and increasing economic disincentives to tobacco use, and establishing smoke-free public places are among the effective actions that deserve active support. The acceptability of tobacco use is to a great extent socially determined.

Evidence supporting this recommendation is of classes: C, M, R

2. Establish Tobacco Use and Second-Hand Smoke Exposure at Nearly Every Visit

   Key Points:

   - Smoke exposure (in home, at day care, etc.) should be established at nearly every visit.
   - Establish the tobacco use status of all patients (and in the case of infants and children, the use status of everyone in the home).

   Smoke exposure (in home, at day care, etc.) should be established at nearly every visit. If there is anyone smoking around the child, regard the infant or child as a passive smoker.

   The only way to accomplish the objectives of this guideline is to establish the tobacco use status of all patients (and in the case of infants and children, the use status of everyone in the home) in/on the chart by staff, and to remind providers of this status in some way.

   Evidence supporting this recommendation is of classes: D, M, R, X

3. Document Tobacco Use Discussion

   Key Point:

   - Documentation should be made of every tobacco use discussion.

   Documentation should be made of every tobacco-use discussion, either in the progress notes or in a separate flow-sheet or card. Documentation is necessary to facilitate follow-up, to enhance coordination between various providers and their support staff, to permit follow-up and referral arrangements, and to allow subsequent visits to build on discussions started earlier.

4. Is the Child Exposed to Smoke?

   Key Point:

- The adult accompanying the child should be advised of the dangers to the child of passive tobacco exposure.

The adult accompanying the child should be advised about the dangers to the child of passive tobacco exposure. Educational and self-help material should be provided. If the user is present, s/he should be encouraged to quit. If the user is a clinic patient and is interested in quitting, s/he should follow-up with his/her primary care provider. See also the National Guideline Clearinghouse (NGC) summary of the Institute for Clinical Systems Improvement (ICSI) guideline Tobacco Use Prevention and Cessation for Adults and Mature Adolescents.

Evidence supporting this recommendation is of class: R

6. Assistance with Tobacco Avoidance

Advise the tobacco user to stop; provide educational and self-help material and offer phone line. If the user is a clinic patient, and is interested in quitting, encourage follow-up within one month.

Children and Adolescents Aged 10 Years and Above Algorithm Annotations

7. Community Intervention

Key Points:

- Tobacco use is the single most preventable cause of disease and death in our society.
- The work group urges ICSI participating medical groups, insurance plans, and employers to actively intervene within their community to reduce tobacco use.

Tobacco use is the single most preventable cause of disease and death in our society. The Centers for Disease Control recommend that tobacco control programs be established that are comprehensive, sustainable and accountable. The goal of a comprehensive tobacco control program is to reduce disease, disability and death related to tobacco use by:

- Preventing the initiation of tobacco use among young people
- Promoting cessation among young people and adults
- Eliminating nonsmokers' exposure to second hand smoke
- Identifying and eliminating the disparities related to tobacco use and its effects among different population groups

The components of a comprehensive tobacco control program include:

- Community programs to reduce tobacco use
- Chronic disease programs to reduce the burden of tobacco related diseases
- School programs

- Enforcement
- Statewide programs
- Counter-marketing
- Cessation programs
- Surveillance and evaluation
- Administration and management

The work group urges ICSI participating medical groups, insurance plans, and employers to actively intervene within their community to reduce tobacco use. Participation in school-based education, limiting youth access to tobacco, restrictions on advertising, counter-advertising and increasing economic disincentives to tobacco use, and establishing smoke-free public places are among the effective actions that deserve active support. The acceptability of tobacco use is, to a great extent, socially determined.

Evidence supporting this recommendation is of classes: C, M, R

8. Establish Patient's Tobacco Use and Secondhand Smoke Exposure at Nearly Every Visit

   The patient's use of tobacco should be established at nearly every visit, as the teen years are the main age at which tobacco use begins and use may occur at any time.

   See Annotation #2, "Establish Tobacco Use and Secondhand Smoke Exposure at Nearly Every Visit."

9. Document Tobacco Use Discussion

   Key Point:

   - All tobacco use discussions should be documented.

   Documentation should be made of every tobacco-use discussion, either in the progress notes or in a separate flow sheet or card. Documentation is necessary to facilitate follow-up, to enhance coordination between various providers and their support staff, to permit follow-up and referral arrangements, and to allow subsequent visits to build on discussions started earlier.

13. Patient Not Interested in Quitting

    Key Point:

    - A "precontemplator" benefits from nonconfrontational messages about importance of quitting and the awareness that provider help is available when ready.

    The scientifically-based concept of readiness stages for behavior change developed by Prochaska and DiClimente has been incorporated into this guideline. This approach requires that the provider first assess readiness to

quit by asking if a user would consider quitting. The strategy taken would then be tailored to the individual user's readiness stage.

A user not ready to consider quitting is called a precontemplator and is helped most when a provider avoids confrontation while conveying both the message that quitting is important and a desire to be helpful when the user is ready to consider quitting. The short-term negative effects of tobacco, such as bad breath, yellowed fingers, and smelly clothes, should be emphasized. The benefits of quitting should also be stressed. These include fewer respiratory illnesses, better performance in sports, and the money saved by not buying tobacco. It can also be noted that it is easier to stop using tobacco in youth than later in adulthood. Educational material should be provided.

Adolescent users who are not ready to quit have been shown to be swayed by information concerning the short-term negative consequences of tobacco.

Evidence supporting this recommendation is of class: R

14. Patient Interested in Quitting

Key Points:

- "Contemplators" should receive support and respectful urging to quit.
- A patient in "preparation" should set a quit date, receive self-help information, and be encouraged to accept follow-up after the quit date.

The contemplator is interested in quitting in the next 1 to 6 months. Contemplators are accepting of support and respectful urging to quit and encouragement to start thinking about a serious plan to do so. Persuasive written, audio, or video information about the pros and cons of quitting may be appropriate for contemplators.

Users in the preparation stage are ready to attempt to quit in the next month. It is always appropriate to request the user to set a quit date within the next 1 to 3 weeks, to provide self-help information or suggestions, and (most importantly) to encourage the user to accept some form of follow-up soon after the quit date. Follow-up can occur by mail or telephone.

Virtually every tobacco-cessation expert and program, including the National Cancer Institute program, recommends asking a tobacco user who is ready to quit to set his/her own quit date. They also recommend some type of follow-up, often a return visit. Because physicians are often reluctant to ask for a follow-up appointment for this purpose and users are unlikely to keep the appointment, alternatives like phone calls are usually substituted.

Evidence supporting this recommendation is of classes: A, M, R

15. Does Parent, Sibling, or Friend Use Tobacco?

17. Assistance with Tobacco Avoidance

Key Point:

- Patients should be assisted in developing refusal skills and given educational materials.

All patients who wish to stop using tobacco or who do not currently use tobacco should be asked if their parents, siblings, or friends use tobacco. If someone does smoke around the patient, the patient should be assisted in developing refusal skills and given educational material.

Adolescents are particularly susceptible to peer pressure. It is important to assist the nonuser in resisting this pressure by assisting the patient in developing refusal skills and by providing the patient with educational material about tobacco use and cessation techniques.

If the person who uses tobacco is present, she or he should be encouraged to quit. If the user is a clinic patient and is interested in quitting, he or she should be given encouragement, materials, and resources at this visit, and referred for follow-up by his or her primary care provider. See also the NGC summary of the ICSI guideline Tobacco Use Prevention and Cessation for Adults and Mature Adolescents.

Minnesotans have high quality free telephone line counseling for smoking cessation. Clinicians are advised to refer patients to their respective health plan quitlines. If a patient does not belong to one of the health plans listed in the original guideline document, s/he should refer to the QUITPLAN Helpline: 1-888-354-PLAN. They are also planning to offer face-to-face counseling soon. It is helpful to provide a handout with tobacco quitline numbers when referring to a quitline. These handouts are available from Blue Cross Blue Shield of Minnesota.

An important message to convey to smokers is that quitline counselors provide expert advice in a friendly and supportive manner.

- Smokers can consult quitlines for assistance about any issue related to tobacco cessation
- Quitline counselors can answer brief questions or provide counseling, depending on the needs of the smoker.
- Quitlines can help smokers who are not quite ready to quit as well as those who have set a quit date.
- Smokers who are not quite ready to quit can receive assistance in figuring out the next steps.
- Quitlines can also help smokers who have quit but are having difficulty maintaining cessation.
- Quitlines can send written self-help materials and may provide free nicotine replacement therapy (NRT).
- The quitlines also can help those who want to know how to support someone who is trying to quit.

Evidence supporting this recommendation is of class: A

Definitions:

Classes of Research Reports:

A. Primary Reports of New Data Collection:

Class A:

- Randomized, controlled trial

Class B:

- Cohort study

Class C:

- Nonrandomized trial with concurrent or historical controls
- Case-control study
- Study of sensitivity and specificity of a diagnostic test
- Population-based descriptive study

Class D:

- Cross-sectional study
- Case series
- Case report

B. Reports that Synthesize or Reflect upon Collections of Primary Reports:

Class M:

- Meta-analysis
- Systematic review
- Decision analysis
- Cost-effectiveness analysis

Class R:

- Consensus statement
- Consensus report
- Narrative review

Class X:

- Medical opinion

CLINICAL ALGORITHM(S)

A detailed and annotated clinical algorithm is provided for Tobacco Use Prevention and Cessation for Infants, Children, and Adolescents.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The guideline contains an annotated bibliography and discussion of the evidence supporting each recommendation. The type of supporting evidence is classified for selected recommendations (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Appropriate interventions in the clinic setting for identification of tobacco-use status in infants, children, and adolescent, and provision of counseling and assistance in tobacco-use cessation
- Decreased exposure of infants and children to passive smoke resulting in decreased morbidity due to passive smoke exposure
- Increased number of tobacco-using patients who will quit

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- These clinical guidelines are designed to assist clinicians by providing an analytical framework for the evaluation and treatment of patients, and are not intended either to replace a clinician's judgment or to establish a protocol for all patients with a particular condition. A guideline will rarely establish the only approach to a problem.
- This clinical guideline should not be construed as medical advice or medical opinion related to any specific facts or circumstances. Patients are urged to consult a health care professional regarding their own situation and any specific medical questions they may have.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Once a guideline is approved for general implementation, a medical group can choose to concentrate on the implementation of that guideline. When four or more groups choose the same guideline to implement and they wish to collaborate with others, they may form an action group.

In the action group, each medical group sets specific goals they plan to achieve in improving patient care based on the particular guideline(s). Each medical group shares its experiences and supporting measurement results within the action group. This sharing facilitates a collaborative learning environment. Action group learnings are also documented and shared with interested medical groups within the collaborative.

Currently, action groups may focus on one guideline or a set of guidelines such as hypertension, lipid treatment, and tobacco cessation.

Detailed measurement strategies are presented in the original guideline document to help close the gap between clinical practice and the guideline recommendations. Summaries of the measures are provided in the National Quality Measures Clearinghouse (NQMC).

Key Implementation Recommendations

The following system changes were identified by the guideline work group as key strategies for health care systems to incorporate in support of the implementation of this guideline.

1. Establish a system whereby the tobacco use of each patient is identified.
2. Establish a system to remind providers to assess attitudes of each tobacco user toward quitting and to provide cessation advice.
3. Establish a system to make it easy for a provider to give a tobacco user self-help quit books, to arrange for quit counseling and to arrange for follow-up after the planned quit date.
4. Establish a system to collect data at least every three months on the success of these interventions and to provide the data to providers and clinic staff to assess implementation success.

RELATED NQMC MEASURES

- Tobacco use prevention and cessation for infants, children and adolescents: percentage of patients' charts showing either that there is no tobacco use/exposure or (if a user) that the current use was documented at the most recent clinician visit.
- Tobacco use prevention and cessation for infants, children and adolescents: percentage of patients with documented tobacco use or exposure at the latest visit who also have documentation that their cessation interest was assessed or that they received advice to quit.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Institute for Clinical Systems Improvement (ICSI). Tobacco use prevention and cessation for infants, children and adolescents. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2004 Jun. 28 p. [25 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1994 May (revised 2004 Jun)

GUIDELINE DEVELOPER(S)

Institute for Clinical Systems Improvement - Private Nonprofit Organization

GUIDELINE DEVELOPER COMMENT

Organizations participating in the Institute for Clinical Systems Improvement (ICSI): Affiliated Community Medical Centers, Allina Medical Clinic, Altru Health System, Aspen Medical Group, Avera Health, CentraCare, Columbia Park Medical Group, Community-University Health Care Center, Dakota Clinic, ENT SpecialtyCare, Fairview Health Services, Family HealthServices Minnesota, Family Practice Medical Center, Gateway Family Health Clinic, Gillette Children's Specialty Healthcare, Grand Itasca Clinic and Hospital, Hamm Clinic, HealthEast Care System, HealthPartners Central Minnesota Clinics, HealthPartners Medical Group and Clinics, Hennepin Faculty Associates, Hutchinson Area Health Care, Hutchinson Medical Center, Lakeview Clinic, Mayo Clinic, Mercy Hospital and Health Care Center, MeritCare, Minnesota Gastroenterology, Montevideo Clinic, North Clinic, North Memorial Health Care, North Suburban Family Physicians, NorthPoint Health &: Wellness Center, Northwest Family Physicians, Olmsted Medical Center, Park Nicollet Health Services, Quello Clinic, Ridgeview Medical Center, River Falls Medical Clinic, St. Mary's/Duluth Clinic Health System, St. Paul Heart Clinic, Sioux Valley Hospitals and Health System, Southside Community Health Services, Stillwater Medical Group, SuperiorHealth Medical Group, University of Minnesota Physicians, Winona Clinic, Winona Health

ICSI, 8009 34th Avenue South, Suite 1200, Bloomington, MN 55425; telephone, (952) 814-7060; fax, (952) 858-9675; e-mail: icsi.info@icsi.org; Web site: www.icsi.org.

SOURCE(S) OF FUNDING

The following Minnesota health plans provide direct financial support: Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica, Metropolitan Health Plan, PreferredOne, and UCare Minnesota. In-kind support is provided by the Institute for Clinical Systems Improvement's (ICSI) members.

GUIDELINE COMMITTEE

Preventive Services Steering Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Work Group Members: David Klevan, MD (Work Group Leader) (HealthPartners Medical Group) (Internal Medicine); Thomas E. Kottke, MD (Mayo Clinic) (Cardiology); Donald A. Pine, MD (Park Nicollet Health Services) (Family Practice); Michael Schoenleber, MD (HealthPartners Medical Group) (Family Practice); David Rossmiller, MD (Family HealthServices Minnesota) (Family Practice); Renee Compo, RN, CNP (HealthPartners Medical Group) (Obstetrics/Gynecology Nurse Practitioner); Janice Taramelli (Methodist Hospital/Park Nicollet Institute) (Health Education); Penny Carson (Institute for Clinical Systems Improvement) (Measurement/Implementation Advisor); Peter Lynch, MPH (Evidence Analyst) (Institute for Clinical Systems Improvement); Pam Pietruszewski, MA (Institute for Clinical Systems Improvement) (Facilitator)

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

In the interest of full disclosure, Institute for Clinical Systems Improvement (ICSI) has adopted the policy of revealing relationships work group members have with companies that sell products or services that are relevant to this guideline topic. The reader should not assume that these financial interests will have an adverse impact on the content of the guideline, but they are noted here to fully inform users. Readers of the guideline may assume that only work group members listed below have potential conflicts of interest to disclose.

Thomas E. Kottke, M.D. receives grant support from Merck, and is a consultant for Bayer and AstraZeneca.

No other work group members have potential conflicts of interest to disclose.

ICSI's conflict of interest policy and procedures are available for review on ICSI's website at www.icsi.org.

GUIDELINE STATUS

This is the current release of guideline.

It updates a previous version: Institute for Clinical Systems Improvement (ICSI). Tobacco use prevention and cessation for infants, children and adolescents. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2003 Jul. 27 p.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Institute for Clinical Systems Improvement (ICSI) Web site.

Print copies: Available from ICSI, 8009 34th Avenue South, Suite 1200, Bloomington, MN 55425; telephone, (952) 814-7060; fax, (952) 858-9675; Web site: www.icsi.org; e-mail: icsi.info@icsi.org.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was updated by ECRI on April 30, 1999. The information was verified by the guideline developer as of April 30, 1999. This summary was updated by ECRI on May 15, 2000, May 7, 2002,December 24, 2002, and most recently on March 25, 2004.

COPYRIGHT STATEMENT

Date Modified: 11/8/2004


FIRSTGOV